STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00158620. Complaint IN00158620- Substantiated. A deficiency related to the allegations is cited at F279. Survey dates: November 18, 19, and 20, 2014 Facility number: 013005 Provider number: 155816 AIM number: NA Survey team: Chuck Stevenson RN, TC Census bed type: SNF: 36 SNF/NF: 10 Residential: 8 Total: 54 Census payor type: Medicare: 36 Medicaid: 10 Total: 46 Sample: 5 This deficiency also reflects State findings cited in accordance with 410	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey (IN00158620) on November 20, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	IAC 16.2.3-1. Quality review completed on November 21, 2014 by Cheryl Fielden, RN.			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop health care plans for a resident with a diagnosis of diabetes mellitus and a potential reaction to a medication (Resident C) and failed to develop health care plans for discharge planning for 2 residents (Residents B and C); 2 residents of 3 reviewed for health care plans in a sample of 5..	F000279	**F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #B and #C have been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS	12/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The record of Resident B was reviewed on 11/18/14 at 1:30 P.M. Diagnoses included, but were not limited to, status post lumbar fusion, adrenal insufficiency, muscle spasms, and peripheral neuropathy. An undated facility "Discharge Summary and Recapitulation of Stay" for Resident B indicated the resident had been admitted to the facility on 10/01/14 and discharged on 10/31/14. It indicated "Res (resident) admitted for spinal fusion here for therapy. Nursing worked with res on pain control (symbol for "and") safety. Discharged home for home care (symbol for "with") no complication." During an in person interview on 11/18/14 at 2:45 P.M. Resident B indicated she believed planning for her discharge had not been adequate. Resident B's record contained no health care plan related to discharge planning. 2. The record of Resident C was reviewed on 11/19/14 at 10:00 A.M. Diagnoses included, but were not limited to, hypertension, gout, low back pain, diabetes mellitus, morbid obesity,		or designee will review all residents with diagnosis of diabetes mellitus, anticipated discharge plans and documented potential reaction to a medication to ensure a health care plan has been developed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted for 5 residents per hallway by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review residents with diagnosis of diabetes mellitus, anticipated discharge plans and documented potential reaction to a medication to ensure a health care plan has been developed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	degenerative joint disease, and osteoarthritis. An undated facility "Discharge Summary and Recapitulation of Stay" for Resident B indicated the resident had been admitted to the facility on 9/27/14 and discharged on 10/17/14. It indicated "Res (resident) admitted S/P (status post) hosp (hospital) stay for chronic pain. Received PT/OT (physical and occupational therapy) for strengthening (symbol for "and") gait. Res discharged home (symbol for "without") any further pain concerns." A hospital history and physical dated 9/25/14 for Resident C indicated: "Assessment/Plan: Myalgias (muscle pain), Diffuse difficulty Walking:...wonder if this could be related to her exposure to atorvastatin (a cholesterol lowering medication). She stated that she was told a few yrs (years) ago to never take (brand name for atorvastatin) again due to the pains it caused her. She was not aware that atorvastatin was (brand name for atorvastatin). History of Present Illness:...Most recent med (medication) added was atorvastatin in May of this yr. (year). When asked			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about prior adverse reactions to meds she does share that she was told by a previous doctor to never take (brand name for atorvastatin) again due to the pains it gave her. Past Medical History: Diagnosis: Diabetes mellitus..." A facility physician's order dated 9/28/14 at 12:00 P.M. indicated "1. Begin (blood sugar testing) QID (4 times per day) before meals and at HS (bed time). 2. Begin (oral diabetic medication) 850 mg. (milligrams) take 1 BID (twice per day)." A physician's order dated 10/09/14 at 10:45 A.M. indicated "1. D/C (discontinue) (blood sugar testing) QID. Begin (blood sugar testing) BID." Resident C's record contained no health care plans related to a diagnosis of diabetes mellitus, a potential reaction to the medication atorvastatin, or discharge planning. During an interview on 11/20/14 at 1:55 P.M. the Director of Health Services indicated she had no additional documentation to provide related to health care plans for Resident B or Resident C.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. A facility policy dated 1/08 received from the Director of Health Services on 11/19/14 at 2:05 P.M. indicated: Purpose: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, or disease in accordance with state and federal guidelines...A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment..." 3.1-35(a)			